Please download and print a copy of the Medical Requirement forms for the Nursing Program, which includes the following items:

1. Required Forms Checklist and Instructions for Medical Forms
2. Required Form A – Health Form Identification, History, Physical, Health Care Provider Attestation
3. Required Form B – Immunization Record
4. Required Form C – Meningitis Information Sheet and Vaccine information
5. Required Form D – Authorization to Release Health, Immunization, Laboratory, Testing and TB Screenings

The Student is responsible for ensuring that all required forms are completed and the physician completes all medical information.

Please read the instructions carefully; complete and send, fax or upload a copy of all required forms to

Health Services
Saint Elizabeth University
Founders Hall
2 Convent Road,
Morristown, NJ 07960
immunization@steu.edu
Phone: 973-290-4132
Fax: 973-290-4182
upload: https://www.steu.edu/meduploads

For questions about nursing medical requirements and clinical clearance please contact the nursing department

Dr. Virginia Clerkin
(973) 290-4570
vclerkin@steu.edu
Nursing
Health and Immunizations
Saint Elizabeth University
2 Convent Road,
Morristown, NJ 07960
TIME SENSITIVE REQUIREMENTS

DEADLINE: IMMEDIATELY - prior to June 1st for fall semester

ALL HEALTH REQUIREMENTS MUST BE COMPLETED TO ATTEND CLASS

NON-COMPLIANCE WILL LEAD TO FINANCIAL FEES $350 AND REGISTRATION HOLDS

READ and FOLLOW ALL INSTRUCTIONS CAREFULLY

Complete and send to Health Services:

Health Services, Saint Elizabeth University, Founders Hall, 2 Convent Road, Morristown, NJ 07960
Fax: 973-290-4182  Upload: https://www.steu.edu/meduploads  Phone: 973-290-4132

For questions about nursing requirements and clinical clearance please contact nursing:
Dr. Virginia Clerkin, (973) 290-4570  vclerkin@steu.edu  2 Convent Road, Morristown, NJ 07960

- The Student is responsible for ensuring that all required FORMS ARE COMPLETED AND THE PHYSICIAN COMPLETES ALL MEDICAL INFORMATION.

☐ REQUIRED FORM A – HEALTH FORM
  - Identification Data
  - Emergency Information
  - Parental Endorsement for Medical Care (as indicated by age)
  - Personal and Family Medical History (reviewed/completed by your physician)
  - History and Physical must be after May 15 annually
  - Health care provider attestation

☐ REQUIRED FORM B – IMMUNIZATION RECORD and annual TB and flu compliance
  - Review requirements/completed by your physician
  - All students must fulfill the vaccine requirements prior to entrance

☐ REQUIRED FORM C – MENINGITIS INFORMATION SHEET
  - All students must read the information about meningitis & the vaccines
  - All students must sign and submit the Meningitis information sheet.

☐ REQUIRED FORM D – AUTHORIZATION to Release Health Forms

To begin clinical rotations, you must receive a Health Clearance from the Adam Safeguard/Sentry MD accounts upload (Directions for creating account attached at the end of this document.

Immunization Requirements – Start Immediately – Time Sensitive Requirements!
Where can you obtain an acceptable record of immunization?
  Employee Health, High school, college, university, healthcare provider, family records.
Acceptable Records? The Record must show exact dates (month, day, year) and be signed by your Physician or health care provider.
DIRECTIONS:

- **History and Physical** must be **after May 15 annually**
- **MMR vaccine** 2 doses or 2 measles, 2 mumps, 2 rubella **AND/or evidence of immunity**: REQUIRED
  - First dose must be after the 1st birthday
  - Be aware! Between the two MMR doses a **minimum of 28 days is required** (single dose vaccines are not available)
  - Copy of lab report must be submitted as evidence of MMR immunity done within **5 years**
    - **Equivocal titers are considered negative, DO NOT ASSUME PRESENT IMMUNITY**
- **Hepatitis B vaccine** –2 or 3 dose series **AND or evidence of immunity**: REQUIRED
  - Copy of lab report required as evidence of immunity. If positive disease - medical clearance.
  - Minimum of 4 weeks between doses 1 and 2
  - Minimum of 8 weeks between doses 2 and 3
  - Minimum of 16 weeks between doses 1 and 3 (for three dose series)
- **Hepatitis C Screening** REQUIRED. Copy of lab report. If **POSITIVE**, medical clearance is required.
- **Tdap (one dose)** Tdap or Td vaccine within 10 years **REQUIRED**
  - Primary series completed
- **Polio vaccine** REQUIRED.
  - Primary series completed or Positive Titer
  - A copy of the Lab report as evidence of immunity.
- **Varicella vaccine** 2 doses and/or documented history of disease - **REQUIRED**
  - AND Copy of lab report as evidence for immunity **REQUIRED**
- **Meningococcal vaccine** (serogroup ACWY)
  - Students less than 22 years old and all on-campus residents – **REQUIRED**
  - Final dose must be administered at or after the age of 16 years **AND within 5 years of entry**
- **Meningitis serogroup B vaccine** – **for age < 23**
- **Meningitis Information Sheet - Form C** **REQUIRED**
  - **REMINDER**: All students must confirm that they have received and read the information about Meningitis and the vaccines by signing the Meningitis Information Sheet (Form C).
- **COVID 19 Vaccine** REQUIRED – must submit vaccination card with Pfizer (2 doses), Moderna (2 doses) or Johnson & Johnson (1 dose)

**ANNUALLY**

- **Influenza VACCINE**: Annually.
- **TB Screening**:
  - **IGRA-Interferon-gamma release assay or PPD/Mantoux testing** – required within SIX MONTHS of entry. **Result must be in mm of induration for the PPD. A COPY of the Lab Report must be submitted to demonstrate evidence of screening.**
  - **Recommended and Optional Vaccines**

  HPV, Hib, Hepatitis A, Pneumococcal, Zoster, Typhoid, Yellow Fever. These vaccines are not required but to promote preventive health care and management they should be discussed with your physician.
PSYCHOLOGICAL AND DISABILITY SERVICES

If you require disability accommodations, you must self-identify and provide appropriate documentation directly to Lisa Seneca, Accessibility Services Coordinator, at 973-290-4261 or Iseneca@st.eu.edu.

Accessibility Services
Saint Elizabeth University
Mahoney Library
2 Convent Road
Morristown, NJ 07960

If you have a mental health condition and/or take psychiatric medication and want Counseling Services to be aware of your history, you must self-identify and provide appropriate documentation directly to: Zsuzsa Nagy, LCSW, Director of Counseling Services, at 973-290-4134 or znagy@st.eu.edu.

Counseling Services
Saint Elizabeth University
Founders Hall
2 Convent Road
Morristown, NJ 07960

If you choose to sign release of information forms, these three service areas can coordinate your care. For further details or questions, please contact these individual offices.

Without the above COMPLETE documented health records and required immunizations, you will be unable attend class, register for future classes and incur financial fines $350.

COMPLETED RECORDS MUST BE RECEIVED BY June 1st

Send Records by mail, fax or upload

Health Services, Saint Elizabeth University, Founders Hall, 2 Convent Road, Morristown, NJ 07960
Fax: 973-290-4182  Phone: 973-290-4132  upload https://www.st.eu/meduploads
Email: immunization@st.eu.edu

For questions about nursing medical requirements and clinical clearance please contact the nursing department
Dr. Virginia Clerkin
Nursing
(973) 290-4570
vclerkin@st.eu.edu
Nursing Program, Immunizations, Saint Elizabeth University, 2 Convent Road, Morristown, NJ 07960

Nursing Students - Instructions for Medical Forms – Updated May 2021
### IDENTIFICATION DATA A (1)

Name: ________________________________________________________________________________

Last / Other surname  First  Middle  Date of Birth

Home Address: ____________________________________________________________

Street  City  State  Zip Code

State/Country of Origin: ________________________ Phone: _________________________

email: _________________________ @ _________________________

Program/Degree: __________ Credits #: ______ First Semester Enrolled: _______ M/Y

Expected Graduation Date: _______ M/Y

Freshman _____ Transfer _____ SEU Leave of Absence: _______ M/Y

SEU Withdrawal: _______ M/Y  SEU Dismissal: _______ M/Y

### HEALTH INSURANCE COVERAGE

- Please include a copy of your insurance card front and back.

Insurance Company: ____________ Address: ____________________________

Group and Policy#: ____________________________

Subscriber’s Name: ____________________________ Subscriber’s DOB: _________

Subscriber’s SS #: ____________________________

### EMERGENCY INFORMATION – contact to be notified in case of emergency

Name: ________________________________________________________________________________

Relationship: ________________________________

Home Address: ____________________________________________________________

tel.#: ____________________________ Home work/cell: ____________________________

Please list another person who can be contacted in case the above person cannot be reached.

Name: ________________________________________________________________________________

Relationship: ________________________________

Tel.#: ____________________________

### PARENTAL ENDORSEMENT FOR MEDICAL CARE

Permission for medical care of minors (A parent’s or guardian’s signature is required)

For students under the age of 18: I hereby give permission to the medical and psychological staff of Saint Elizabeth University Health Services to examine and treat my minor child for all medical problems and injuries that may occur while he or she is at Saint Elizabeth University.

DATE: __________ SIGNATURE: ____________________________ RELATIONSHIP: ____________________________

### SOURCES OF HEALTHCARE

List the names, addresses and telephone numbers of Physicians, psychologists, or other health care providers you now consult.

<table>
<thead>
<tr>
<th>Name/specialty</th>
<th>Address</th>
<th>City, State</th>
<th>Telephone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name/specialty</th>
<th>Address</th>
<th>City, State</th>
<th>Telephone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Health History Questionnaire: A (2)**

Answer ALL questions  Explain All YES Answers

<table>
<thead>
<tr>
<th>ALLERGY</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any significant allergy to food, medications, insects, pollen?</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>List known allergies and type of reaction to them:</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Medication</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Food</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Environmental</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>Vaccines</td>
<td>☐</td>
<td>☑</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICATIONS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you take any medications regularly, including herbas, supplements and over the counter drugs?</td>
</tr>
<tr>
<td>Medications: List all medications and dosage that you take regularly prescription and non-prescription (ex. Anxiety, ADD, depression, birth control, asthma, diabetes etc.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOSPITALIZATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever been admitted to a hospital?</td>
</tr>
<tr>
<td>Have you ever had surgery?</td>
</tr>
<tr>
<td>Have you ever had any ER visits?</td>
</tr>
<tr>
<td>Have you ever had any severe injury?</td>
</tr>
<tr>
<td>List:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PAST ILLNESSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis, mononucleosis, childhood diseases, HIV</td>
</tr>
<tr>
<td>Loss or absence of any body parts.</td>
</tr>
<tr>
<td>Severe/frequent colds or flu</td>
</tr>
<tr>
<td>Serious illness or injury</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any problems with your eyes, ears, nose or throat?</td>
</tr>
<tr>
<td>Hearing impairment</td>
</tr>
<tr>
<td>Loss of eye or eyesight</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CARDIOVASCULAR:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart murmur/ palpitations</td>
</tr>
<tr>
<td>Chest pain</td>
</tr>
<tr>
<td>Rheumatic fever</td>
</tr>
<tr>
<td>High blood pressure</td>
</tr>
<tr>
<td>Irregular heartbeat</td>
</tr>
<tr>
<td>Blood clots (not menstrual clots)</td>
</tr>
<tr>
<td>Enlarged heart</td>
</tr>
<tr>
<td>Mitral valve prolapse</td>
</tr>
<tr>
<td>Fainting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BLOOD:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESPIRATORY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
</tr>
<tr>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Chest infection (pneumonia)</td>
</tr>
<tr>
<td>Do you smoke cigarettes?</td>
</tr>
<tr>
<td>How many?</td>
</tr>
<tr>
<td>Shortness of breath</td>
</tr>
<tr>
<td>Wheezing</td>
</tr>
<tr>
<td>Chronic cough</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SKIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any problems with your skin?</td>
</tr>
<tr>
<td>Skin rashes</td>
</tr>
<tr>
<td>Acne</td>
</tr>
<tr>
<td>Eczema</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ENDOCRINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thyroid disease</td>
</tr>
<tr>
<td>Diabetes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>URINARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired function of any part of your urinary tract</td>
</tr>
<tr>
<td>Loss of a kidney</td>
</tr>
<tr>
<td>Recurrent urinary infection</td>
</tr>
<tr>
<td>Kidney Infection</td>
</tr>
<tr>
<td>Kidney stones</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MENTAL HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any problems with your emotional health, requiring any form of therapy, including medications?</td>
</tr>
<tr>
<td>Did you ever lie to anyone about your gambling?</td>
</tr>
<tr>
<td>Does anyone presently in your life hurt you or make you feel afraid?</td>
</tr>
<tr>
<td>History of depression?</td>
</tr>
<tr>
<td>History of self-harm or harm to others?</td>
</tr>
<tr>
<td>History of abuse physically, emotionally or sexually?</td>
</tr>
<tr>
<td>Learning disabilities?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRUG AND ALCOHOL USAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever felt you should cut down on your drinking?</td>
</tr>
<tr>
<td>Have people annoyed you by criticizing your drinking?</td>
</tr>
<tr>
<td>Have you ever had a drink first thing in the morning to steady your nerves or rid you of a hangover?</td>
</tr>
<tr>
<td>Smoke cigarettes?</td>
</tr>
<tr>
<td>Please give specific information about drug usage (ex. Marijuana, pain medication, ecstasy)</td>
</tr>
</tbody>
</table>

A (3) Name: _______________________
DOB: _______________________

BLOOD: Yes No
Check the following conditions which have appeared in your immediate family, indicating the person’s relationship to you. (Ex. Father Cancer)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Parent</th>
<th>Grandparent</th>
<th>Other Relative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer or Tumor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Cholesterol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraine</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sickle cell anemia / trait
Heart Disease
Sudden death before age 50
Stroke
Kidney Disease / Bladder Disease
Thyroid Disease
Alcoholism / Drug Abuse
Learning disability
Depression
Mental Illness
Tuberculosis
GYN Disorders
Rheumatology
Seizure

Are your parents living? _____ # of brothers living _____ # of sisters living _____

If deceased, give relationship and cause of death and age of death _______________________

To the Student: I certify that the statements are true to the best of my knowledge.

Student Signature: __________________________ print name __________________________ Date: __/__/____

History Reviewed by Physician/PA/NP - Signature: __________________________ Date: __/__/____
Physical Examination A (4)

Health History must be reviewed by the physician (LIP)

Physical exam to be completed by the physician and performed within one year prior to entrance to the University

Patient Name __________________________ Date of Birth ____________

Legal Sex M/F Gender Identity: _______ DATE OF EXAM / /

Vision: uncorrected Right 20/ _____ Left 20/ _____; with glasses/contacts Right 20/ _____ Left 20/ _____

Hearing: normal ☐ Yes ☐ No Abnormal________ Color Vision ☐ normal ☐ abnormal________________

Height ______ Weight ______ BP _______ P _______ Resp _______ Peak Flow (as indicated) ____________

<table>
<thead>
<tr>
<th>System</th>
<th>Satisfactory</th>
<th>Describe Abnormality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose, throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck, thyroid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest, lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen, liver, kidneys, spleen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphatic’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hernia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pelvic (if indicated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rectal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremities, back, spine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Laboratory Tests: URINALYSIS

BLOOD Cholesterol (Fasting) _______ CBC _______ Sickle Cell Screening and EKG for Athletes _______

Additional labs as indicated __________________________________________________________

Impression/Diagnosis/Plan: recommendations, continuing treatment, restriction, medications should be noted: (attach as needed)

____________________________________________________________________________________
____________________________________________________________________________________

Applicant may participate in all University activities: including sports, physical education and intramurals, nursing activities and responsibilities
☐ Without restriction
☐ With the following restrictions and reason: ________________________________________________

History Reviewed & Student Examined by:

Physician name (print): __________________________ Date ________________

Signature/Stamp ____________________________________________

Address ___________________________________________ Phone ________________ Fax ____________

NURSING Form A– HISTORY & PHYSICAL must be reviewed by the physician
Updated as of May 2021
Healthcare Provider Attestation FORM A (5)

Part A: To be completed by Student

Name __________________________________________   _____ /_____/_____

Last/Other Surname   First   Middle   Date of Birth (mm/dd/yyyy)

Home Address _______________________________________________________

Street                                  City                      State           Zip Code

State/Country of Origin _________________________________

Email ________________________________________________

Cell Phone ___________________________   Home Phone ___________________

Part B: To be completed by Healthcare Provider

Attestation:
I have reviewed the immunization record, tuberculosis screening results, and Health History Questionnaire, and examined the above student on (date) _____/_____/. The student is in good health, is free from evidence of communicable disease and does not pose a health risk to students or employees at Saint Elizabeth University or to patients and employees of the clinical agencies utilized during clinical rotations.

_____________________________   _____________________________
Signature                        Date

_____________________________
Print Name

__________________________
Street Address                  City                      State

__________________________
Phone Number                   Fax

Office Stamp:
**REQUIRED FORM B – SAINT ELIZABETH UNIVERSITY**  
**START IMMEDIATELY – TIME SENSITIVE REQUIREMENTS!**

**IMMUNIZATION RECORD NURSING B(1)**

**REQUIRED VACCINES – read all instruction documents carefully**

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Dates Given</th>
<th>Saint Elizabeth University and NJ State Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR</td>
<td>#1/<em><strong>/</strong></em>  #2/<em><strong>/</strong></em> 1st dose given after 1st birthday Minimum of 4 weeks between doses</td>
<td>2 doses</td>
</tr>
<tr>
<td>AND positive immune titers Measles</td>
<td>#1/<em><strong>/</strong></em>  #2/<em><strong>/</strong></em> AND/OR Positive Titer Date: <em><strong>/</strong></em>/___ Required copy of lab report within 5 years</td>
<td>AND / or</td>
</tr>
<tr>
<td>Mumps</td>
<td>#1/<em><strong>/</strong></em>  #2/<em><strong>/</strong></em> AND/OR Positive Titer Date: <em><strong>/</strong></em>/___ Required copy of lab report within 5 years</td>
<td>Positive titers within 5 years</td>
</tr>
<tr>
<td>Rubella</td>
<td>#1/<em><strong>/</strong></em>  #2/<em><strong>/</strong></em> AND/OR Positive Titer Date: <em><strong>/</strong></em>/___ Required copy of lab report within 5 years</td>
<td>A Copy of the lab reports must be submitted as evidence of immunity.</td>
</tr>
<tr>
<td>Meningococcal Vaccine Serogroup ACWY Information Sheet</td>
<td>#1/<em><strong>/</strong></em>  #2/<em><strong>/</strong></em></td>
<td>All &lt; 22 years and all college residents. Final dose must be at or after the age of 16 years old AND within five years of entry</td>
</tr>
<tr>
<td>Meningitis Serogroup B</td>
<td>#1/<em><strong>/</strong></em>  #2/<em><strong>/</strong></em>  #3/<em><strong>/</strong></em> Trumemba Bersero</td>
<td>Required for students ≤ 23 years of Age As recommended by the CDC</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>#1/<em><strong>/</strong></em>  #2/<em><strong>/</strong></em>  #3/<em><strong>/</strong></em> Engerix B Recombivax B Hepisav B</td>
<td>3 dose series/ 2 dose series AND/OR a positive antiHBs (must include copy of lab reports as evidence of immunity) Medical clearance if positive HbsAg Minimum of 4 weeks between doses 1 and 2 Minimum of 8 weeks between doses 2 and 3 Minimum of 16 weeks between doses 1 and 3</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>HepC ab negative positive Date: <em><strong>/</strong></em>/___</td>
<td>Screening If Positive, medical clearance needed Copy of lab results</td>
</tr>
<tr>
<td>COVID 19</td>
<td>#1/<em><strong>/</strong></em>  #2/<em><strong>/</strong></em> Pfizer Moderna Johnson and Johnson other</td>
<td>As per CDC and ACIP</td>
</tr>
<tr>
<td>Tdap Td</td>
<td>Tdap/<em><strong>/</strong></em> Td/<em><strong>/</strong></em></td>
<td>Tdap 1 dose Tdap or Td within 10 years</td>
</tr>
<tr>
<td>Polio</td>
<td>Primary series: Oral Injectable</td>
<td>Completed Primary series or Positive Titer</td>
</tr>
</tbody>
</table>

**Name____________________________________  DOB____________**
### Varicella (Chicken Pox)

<table>
<thead>
<tr>
<th></th>
<th>#1 <em><strong>/</strong></em>/___</th>
<th>#2 <em><strong>/</strong></em>/___</th>
<th>2 doses varicella vaccine or history of disease AND positive titer</th>
</tr>
</thead>
<tbody>
<tr>
<td>AND/OR Positive Titer Date</td>
<td><em><strong>/</strong></em>/___</td>
<td>History of disease</td>
<td>□ No □ Yes Date <em><strong>/</strong></em>/___</td>
</tr>
<tr>
<td>Minimum of 4 weeks between doses if age &gt; 13</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Interferon-gamma release assay tests (IGRA)

- Interferon-gamma release assay tests (IGRA) ___/___/___ □ pos.
- copy of report
- or
- 1) PPD ___/___/___ □ result ___mm
  - Planted
  - Read
- 2) PPD ___/___/___ □ result ___mm
  - Planted
  - Read

- Positive PPD in past ___/___/___
- BCG history ___/___/___

If PPD or Interferon-gamma release assay tests (IGRA) is positive, chest x-ray is required:

- chest x-ray ___/___/___ □ normal □ abnormal
- INH treatment began ___/___/___ completed ___/___/___

### Flu Vaccine

<table>
<thead>
<tr>
<th></th>
<th>Annual Date <em><strong>/</strong></em>/___</th>
</tr>
</thead>
</table>

**RECOMMENDED & OPTIONAL VACCINES**

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Dates Given</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPV</td>
<td>#1 <em><strong>/</strong></em>/___ #2 <em><strong>/</strong></em>/___ #3 <em><strong>/</strong></em>/___</td>
<td>As per the CDC</td>
</tr>
<tr>
<td>Hib</td>
<td><em><strong>/</strong></em>/___</td>
<td>Primary series completed</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>#1 <em><strong>/</strong></em>/___ #2 <em><strong>/</strong></em>/___</td>
<td>As per the CDC 6-12 months between doses 1 and 2</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>#1 <em><strong>/</strong></em>/___ #2 <em><strong>/</strong></em>/___</td>
<td>As per the CDC</td>
</tr>
<tr>
<td>Poly saccharide (PPV)</td>
<td>□ Conjugate (PCV)13</td>
<td>□ PPSV 23</td>
</tr>
<tr>
<td>Zoster</td>
<td>#1 <em><strong>/</strong></em>/___</td>
<td>As per the CDC</td>
</tr>
<tr>
<td>Typhoid</td>
<td>#1 <em><strong>/</strong></em>/___</td>
<td>Travel</td>
</tr>
<tr>
<td>Yellow Fever</td>
<td>#1 <em><strong>/</strong></em>/___</td>
<td>Travel</td>
</tr>
<tr>
<td>Shingles</td>
<td>#1 <em><strong>/</strong></em>/___ #2 <em><strong>/</strong></em>/___</td>
<td>2-6 months between doses 1 and 2</td>
</tr>
<tr>
<td></td>
<td>□ Shingrix, □ Zostavax</td>
<td>As per the CDC</td>
</tr>
</tbody>
</table>

**Student Name: ___________________________ DOB ___/___/___**

**HEALTH CARE PROVIDER**

<table>
<thead>
<tr>
<th>Signature</th>
<th>Print Name</th>
<th>Date</th>
</tr>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<table>
<thead>
<tr>
<th>Telephone</th>
<th>Fax</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Send Health Immunization Records by mail, upload or fax

Saint Elizabeth University
Health Services
Founders Hall
2 Convent Road
Morristown, NJ 07960
Fax: (973) 290-4182
Phone: (973) 290-4175, 4132
Upload: https://www.steu.edu/meduploads

For questions about nursing requirements and clinical clearance please contact nursing:

Dr. Virginia Clerkin, (973) 290-4570 vclerkin@st.eu.edu
Department of Nursing
Saint Elizabeth University
2 Convent Road
Morristown, NJ 07960
REQUIRED FORM C: MENINGITIS INFORMATION SHEET
REQUIRED FOR ALL STUDENTS

Meningococcal Disease among University Students
(Read about meningitis and the vaccine on the VACCINE INFORMATION STATEMENT)

In accordance with New Jersey State Law and Saint Elizabeth University, all college students must complete and return this form to the address below.

1) The University is to provide information about meningococcal meningitis, the disease, its severity, causes, disease prevention, treatment and the availability of the vaccine to prevent disease to all their students prior to matriculation (please see attached Meningococcal Disease Information Statement).

2) Meningitis Vaccine recommendations are as per The Center for Disease Control (CDC) and The Advisory Committee on Immunization Practices (ACIP). Read this information on the Vaccine Information Statement, “Who should get Meningococcal vaccine and when.”

3) The University is to document the student’s receipt of the meningococcal information and their decision whether or not to receive a meningitis vaccine.

Students may go to their private physician or other healthcare provider for administration of the meningitis vaccine. Arrangements can be made with Saint Elizabeth University Health Services for administration of the meningitis vaccine, if needed.

Complete and Sign all indicated below:

Yes ☐ No ☐ I have received information (What you need to know – Vaccine Information Statement) about meningitis, the vaccine, and its availability.

Yes ☐ No ☐ I have received the meningococcal (serogroup ACWY) vaccine. See Vaccine Information Statement as to “Meningococcal vaccines what you need to know”.

Date #1 __/__/__  #2 __/__/__

Yes ☐ No ☐ I have received the meningitis (serogroup B) vaccine. See Vaccine Information Statement as to “Serogroup B Meningococcal vaccine: what you need to know”.

Date #1 __/__/__  #2 __/__/__  #3 __/__/__

Yes ☐ I have read the information regarding meningococcal meningitis disease. I understand the risks and benefits of immunization against meningococcal meningitis. I have decided at this time that I will NOT obtain the immunization against meningococcal meningitis disease. I understand that I may choose in the future to be immunized against meningococcal meningitis.

Name (please print) ___________________________ Date ______________________

Signature ___________________________

(If student is under the age of 18 a parent’s or guardian’s signature is required)

This signature shall become part of the student’s health record and is being required by New Jersey law, P.L. 2000c.25.

Send or upload this required form to: https://www.steu.edu/meduploads

Saint Elizabeth University
Health Services – Founders Hall
2 Convent Road
Morristown, NJ 07960

PHONE: (973) 290-4132, 4175  FAX: (973) 290-4182

Any questions, please call Immunization Information Line: (973) 290-4388

immunization@steu.edu

GRADUATE & CONTINUING STUDIES – MENINGITIS INFORMATION SHEET REQUIRED FORM #3
Updated May 2021
Required Form – D

Authorization to release information to the SEU Nursing Program

Name ___________________________________________ Date of Birth (mm/dd/yyyy)

Last /Other Surname First Middle

Home Address ____________________________________________________________

Street City State Zip Code

State/Country of Origin ______ Telephone ____________________________

Email: ___________________________ Cell: __________________ Home: ___________________

By signing below, I am authorizing the release of my health and immunization records and results of my tuberculosis screening and tests results as documented in health forms as well as the Healthcare Provider Attestation Statement to the Nursing Program in order to maintain a copy in my student record.

I am furthermore authorizing the Nursing Program to release those records to all clinical sites to which I am assigned for my supervised clinical practice experiences.

Please forward a copy of my Health and Immunization records, TB Screening, Testing and Healthcare provider Attestation forms records to:

Saint Elizabeth University
Nursing Program
2 Convent Road
Morristown, NJ 07960
Attention: Health and Immunizations
Dr. Virginia Clerkin

Print Name: ______________________________________________________________________

Signature ___________________________ ___________________________ Date ________________

Questions/Concerns please call Nursing (973) 290-4570  vclerkin@steu.edu
Authorization to Release Medical and Immunization Records to Saint Elizabeth University Health Services

Date _______________________________________

Student Name __________________________________________________________

Date of Birth _____ / _____ / ______

Address __________________________________________________________________________________________

City ___________________________ State___________________________ Zip Code__________________________

Phone Number_________ - ___________ - ___________

I request and authorize (High School, University, Healthcare Provider, School Nurse)
____________________________________________________________________________________________________

to release (check all those that are indicated)

☐ Immunization Records ☐ Medical Records

to Health Services at Saint Elizabeth University. Please forward my records to:

Saint Elizabeth University
Health Services - Founders Hall
2 Convent Road
Morristown, NJ 07960
Attention: Priya Shrestha, Coordinator, Medical Records

If you wish, you may upload the information to www.steu.edu/meduploads or fax to (973) 290-4182. Questions/Concerns, please call (973) 290-4132 or 4175.

Signature/Date______________________________________________________________________________

Name of Parent or Guardian (if under 18) ________________________________________________________

Signature of Parent or Guardian (if under 18) ______________________________________________________

Relationship to patient ____________________________________________________________
Why get vaccinated?

Meningococcal ACWY vaccine can help protect against meningococcal disease caused by serogroups A, C, W, and Y. A different meningococcal vaccine is available that can help protect against serogroup B.

Meningococcal disease can cause meningitis (infection of the lining of the brain and spinal cord) and infections of the blood. Even when it is treated, meningococcal disease kills 10 to 15 infected people out of 100. And of those who survive, about 10 to 20 out of every 100 will suffer disabilities such as hearing loss, brain damage, kidney damage, loss of limbs, nervous system problems, or severe scars from skin grafts.

Anyone can get meningococcal disease but certain people are at increased risk, including:
- Infants younger than one year old
- Adolescents and young adults 16 through 23 years old
- People with certain medical conditions that affect the immune system
- Microbiologists who routinely work with isolates of N. meningitidis, the bacteria that cause meningococcal disease
- People at risk because of an outbreak in their community

Adolescents need 2 doses of a meningococcal ACWY vaccine:
- First dose: 11 or 12 year of age
- Second (booster) dose: 16 years of age

In addition to routine vaccination for adolescents, meningococcal ACWY vaccine is also recommended for certain groups of people:
- People at risk because of a serogroup A, C, W, or Y meningococcal disease outbreak
- People with HIV
- Anyone whose spleen is damaged or has been removed, including people with sickle cell disease
- Anyone with a rare immune system condition called “persistent complement component deficiency”
- Anyone taking a type of drug called a complement inhibitor, such as eculizumab (also called Soliris®) or ravulizumab (also called Ultomiris®)
- Microbiologists who routinely work with isolates of N. meningitidis
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa
- College freshmen living in residence halls
- U.S. military recruits

Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:
- Has had an allergic reaction after a previous dose of meningococcal ACWY vaccine, or has any severe, life-threatening allergies.

In some cases, your health care provider may decide to postpone meningococcal ACWY vaccination to a future visit.

Not much is known about the risks of this vaccine for a pregnant woman or breastfeeding mother. However, pregnancy or breastfeeding are not reasons to avoid meningococcal ACWY vaccination. A pregnant or breastfeeding woman should be vaccinated if otherwise indicated.
People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting meningococcal ACWY vaccine.

Your health care provider can give you more information.

### 4 Risks of a vaccine reaction

- Redness or soreness where the shot is given can happen after meningococcal ACWY vaccine.
- A small percentage of people who receive meningococcal ACWY vaccine experience muscle or joint pains.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

### 5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call 9-1-1 and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at www.vaers.hhs.gov or call 1-800-822-7967. VAERS is only for reporting reactions, and VAERS staff do not give medical advice.

### 6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at www.hrsa.gov/vaccinecompensation or call 1-800-338-2382 to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

### 7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (1-800-CDC-INFO) or
  - Visit CDC’s www.cdc.gov/vaccines

Vaccine Information Statement (Interim)

Meningococcal ACWY Vaccines

8/15/2019 | 42 U.S.C. § 300aa-26
Meningococcal B Vaccine: What You Need to Know

1. Why get vaccinated?

Meningococcal B vaccine can help protect against meningococcal disease caused by serogroup B. A different meningococcal vaccine is available that can help protect against serogroups A, C, W, and Y.

Meningococcal disease can cause meningitis (infection of the lining of the brain and spinal cord) and infections of the blood. Even when it is treated, meningococcal disease kills 10 to 15 infected people out of 100. And of those who survive, about 10 to 20 out of every 100 will suffer disabilities such as hearing loss, brain damage, kidney damage, loss of limbs, nervous system problems, or severe scars from skin grafts.

Anyone can get meningococcal disease but certain people are at increased risk, including:
- Infants younger than one year old
- Adolescents and young adults 16 through 23 years old
- People with certain medical conditions that affect the immune system
- Microbiologists who routinely work with isolates of N. meningitidis, the bacteria that cause meningococcal disease
- People at risk because of an outbreak in their community

2. Meningococcal B vaccine

For best protection, more than 1 dose of a meningococcal B vaccine is needed. There are two meningococcal B vaccines available. The same vaccine must be used for all doses.

Meningococcal B vaccines are recommended for people 10 years or older who are at increased risk for serogroup B meningococcal disease, including:
- People at risk because of a serogroup B meningococcal disease outbreak
- Anyone whose spleen is damaged or has been removed, including people with sickle cell disease
- Anyone with a rare immune system condition called “persistent complement component deficiency”
- Anyone taking a type of drug called a complement inhibitor, such as eculizumab (also called Soliris®) or ravulizumab (also called Ultomiris®)
- Microbiologists who routinely work with isolates of N. meningitidis

These vaccines may also be given to anyone 16 through 23 years old to provide short-term protection against most strains of serogroup B meningococcal disease; 16 through 18 years are the preferred ages for vaccination.

3. Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:
- Has had an allergic reaction after a previous dose of meningococcal B vaccine, or has any severe, life-threatening allergies.
- Is pregnant or breastfeeding.

In some cases, your health care provider may decide to postpone meningococcal B vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting meningococcal B vaccine.

Your health care provider can give you more information.
Risks of a vaccine reaction

- Soreness, redness, or swelling where the shot is given, tiredness, fatigue, headache, muscle or joint pain, fever, chills, nausea, or diarrhea can happen after meningococcal B vaccine. Some of these reactions occur in more than half of the people who receive the vaccine.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call 9-1-1 and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

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How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (1-800-CDC-INFO) or
  - Visit CDC’s www.cdc.gov/vaccines

Vaccine Information Statement (Interim)

Meningococcal B Vaccine

8/15/2019 | 42 U.S.C. § 300aa-26
Dear Student,

The Joint Commission on Accreditation of Healthcare Organizations (TJC) now requires all healthcare students to have their identity verified and a criminal history search conducted prior to being allowed to participate in any cooperative educational program. In order to facilitate these requirements, Saint Elizabeth University has engaged Adam Safeguard to provide necessary service.

The required components that will be included in the required package for your program will include:

- Background screening to include a Social Security Trace, National Sex Offender Search, an OIG Sanction Search, Multi State Database Criminal History Search and a New Jersey Criminal History Search. ($53 Fee)
- 13 Panel Urine Drug Screening ($59 Fee)
- Compliance Tracking Service ($27 Fee)
- Your Social Security Trace will dictate if additional venues will be searched. Due to your clinical requirements, if an address outside of NJ location is developed, we are required to search the location for criminal history. The cost for additional locations will be $10 plus any fees charged by the court involved. (All subject to NJ Sales Tax)

INSTRUCTIONS:

- Navigate to www.adamsafeguardstudents.com
- Click on the “Order Student Background” tab
- Choose from the School Codes below to begin the ordering process
- Enter School Code: seuln

Upon successful completion of the ordering process, you will receive emails containing information via e-mail within 2 business days to complete your Drug Screening and your Compliance Tracking package.

PLEASE NOTE:

- The charges on your credit card will reflect the name Nationwide Screening Services.
- For those not utilizing a credit card you should complete the form, print it and send it with a money order to NSS, 1187 Washington Street, Suite #2, Toms River, NJ 08753
- Due to the timeframe involved in the return of the NJ Statewide Criminal History Searches (10 business days) we ask that you do not contact Adam Safeguard with inquiries regarding completion of searches before the 10 day mark. Unfortunately we cannot inquire the status of these reports, nor can we expedite them in any way.

If you have any questions regarding the ordering process, please don’t hesitate to contact Adam Safeguard at (732) 506-6100.
Frequently Asked Questions:

• Will I be charged if I have lived outside of NJ? If so, how much?
  - Yes. The charge is $10 for each location (plus county court fees if any)

• Will my prior arrest, criminal history, conviction, etc. show up?
  - We do not know what arrests, convictions, etc. will show up until the searches have been run.

• How long does the search take?
  - The search will take about 10 business days to complete if the record is clear. If a hit is recovered, it could take about two, even three weeks, to come back depending on the availability of any additional information that may be required to obtain. Unfortunately we cannot expedite this process, nor can we contact the State Police for updates on results.

• What crimes/convictions/arrests will keep me out of the program?
  - The education and/or medical facilities will determine which applicants they will accept and deny based on the Background Report. Adam Safeguard does not have any authority to make these decisions.

• Who will have access to/see my report? My credit card number? My SS Number?
  - Adam Safeguard will have access to all three indicated above. The medical facility will have access to the reports, which will contain your SS Number.

• When/How will the school receive my report?
  - The education and/or medical facility will be directly linked to our system and they will be able to log in and view your report as soon as it is completed.

• What do I do if an arrest/conviction shows up on my report and it is not me?
  - Adam will provide you with information on how to dispute/deny/admit/correct any discrepancies in your criminal history. These are one page forms that can be found on our web site under “TJC Compliance”.

• What do I do if an address that isn’t mine shows up on my Social Security Trace?
  - You may download a form from the web site listed above that will direct you on how to correct any discrepancies found in your Social Security Trace.

• What if I had a PO Box in another state but never lived there?
  - We will still need to run a criminal search in that state, because the general idea is that you still had the opportunity to commit a crime in that area, resident or not.